

Health Reform in Iowa: Continuing Improvement Comprehensive Strategies

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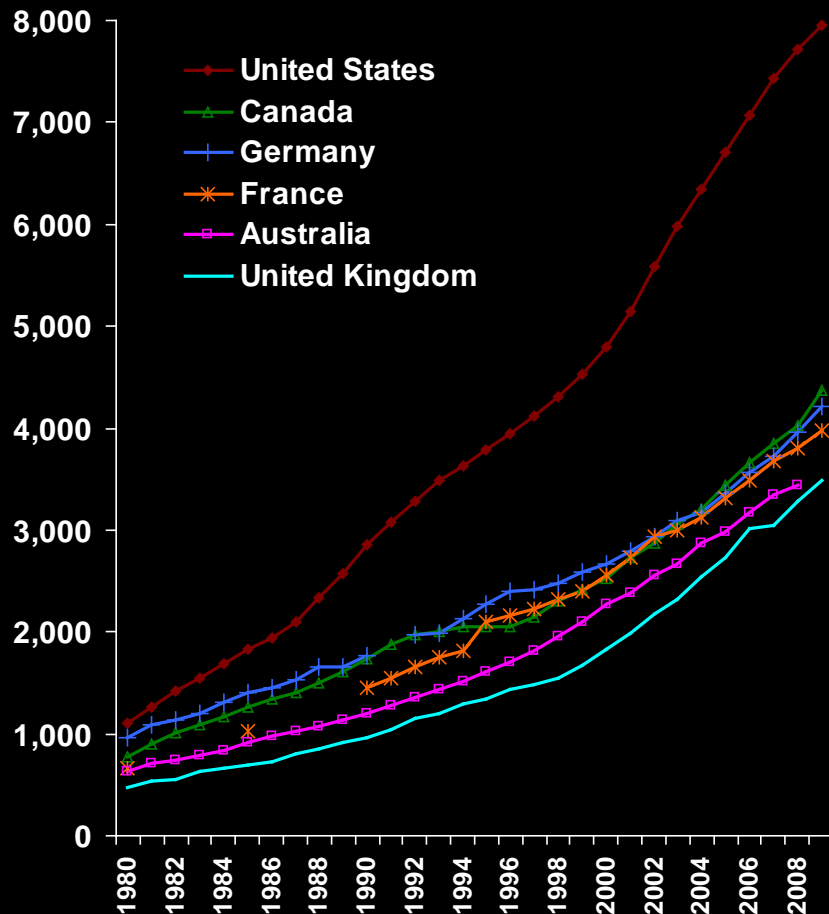
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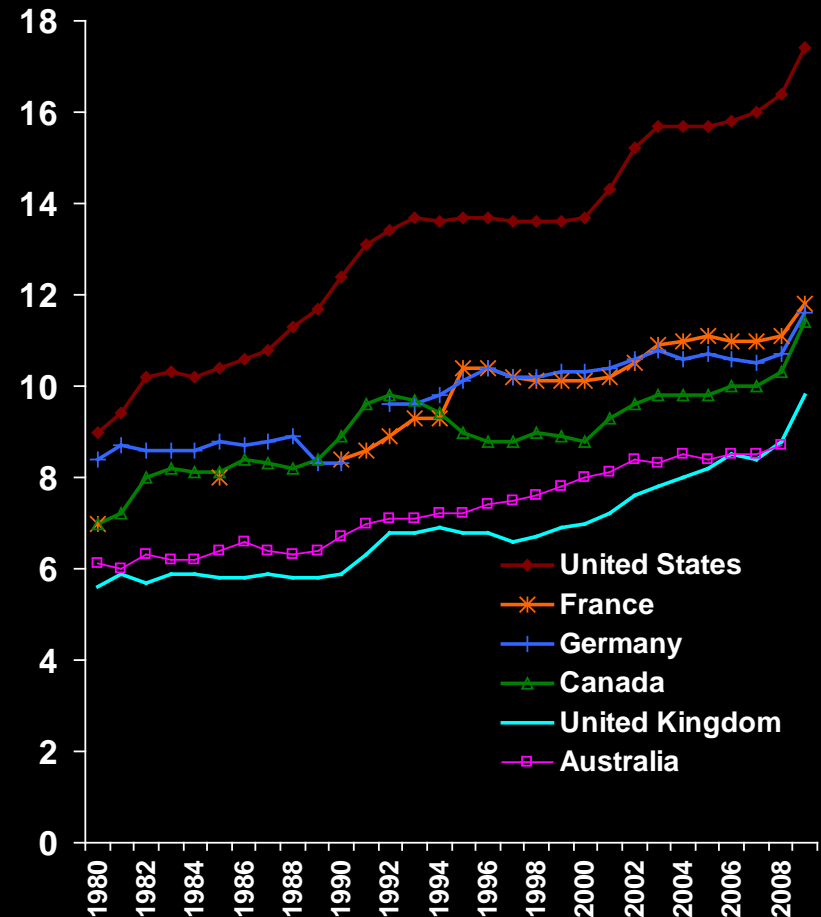
The University of Iowa

International Comparison of Spending on Health, 1980–2009

Average spending on health per capita (\$US)



Total expenditures on health as percent of GDP



“Every system is perfectly constructed to produce the results it achieves”

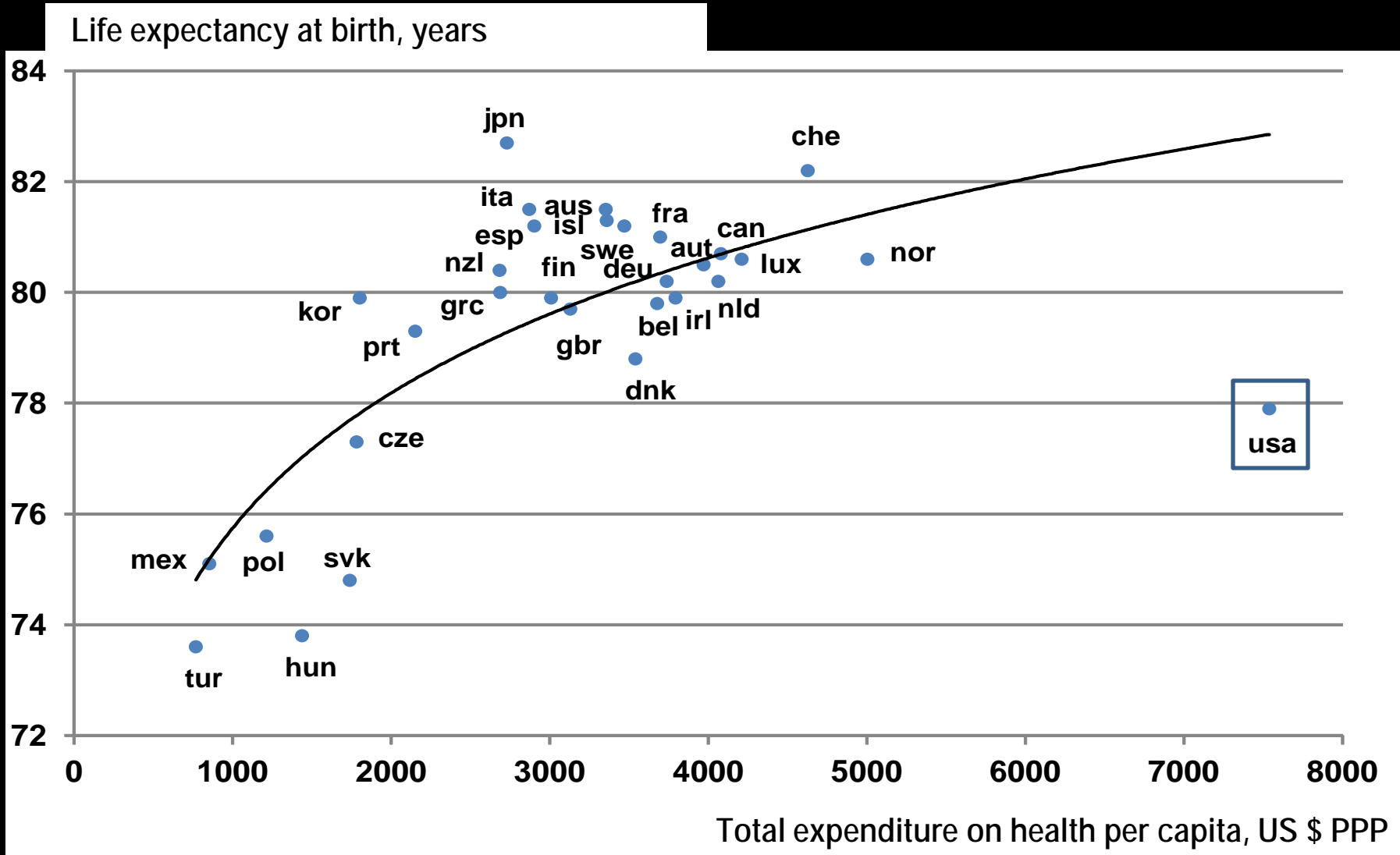
Peter Senge, *The Fifth Discipline*, 1990



**“We don’t have a health care system in America;
We have a sick care system”**

Sen. Tom Harkin

Life Expectancy Compared with GDP Per Capita for Selected Countries



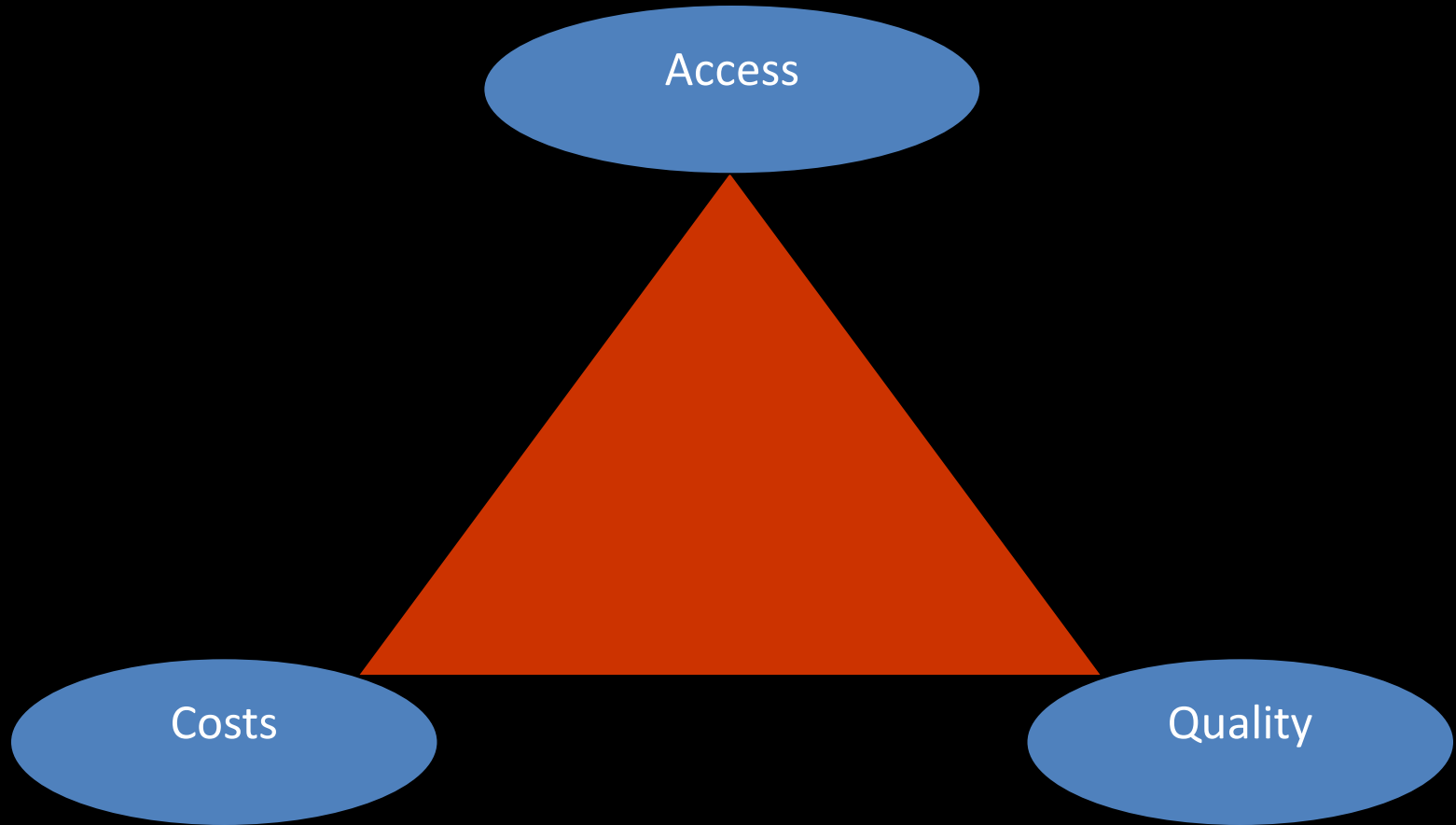
“Quality of care is highly variable, and opportunities are routinely missed to prevent disease, disability, hospitalization, and mortality.”

Commonwealth Fund, *Why Not the Best*, 2008

Infant Mortality Rate



Targets for Healthcare Reform



Historical Responses to Health Care

- Begins With Cost -

- Restrict Supply - e.g., certificate of need; nursing home moratoria (1970's)
- Restrict Price - e.g., rate setting (1980's), provider fee cuts
- Restrict Demand - e.g., reduce eligibility, create managed care (1990's)
- Distribute Responsibility – e.g. higher deductibles, health care savings accounts (2000's)
- Expand Coverage – Affordable Care Act (2010's)

Iowa Has Taken a Broader View

Leadership Consortium on Health Care Reform (1990 – 1992)

- Health care coverage for all
- Cost management
- Improvement of health care quality and safety
- Equitable financing
- Simplified administration

Iowa Health Reform Council (1993-1994)

Problem Statement

- Long term health care cost increases
- Lack of understanding about quality
- Lack of personal responsibility by all parties
- Complex and confusing health care system
- Societal issues affecting health care for which reform alone cannot provide an answer.

Iowa Health Reform Council (1993-1994)

Statement of Principles

- Access to a standard level of services for all
- Affordable care that balances cost, quality and access
- Continuous improvement in quality and value
- Creating appropriate incentives to encourage accountability
- Facilitate the development of coordinated delivery systems
- Government, employers and individuals pay their fair share.

Iowa's Health Reform Transition Team

(Final Report - 1996)

- Structures for voluntary Health Insurance Purchasing Cooperatives (HIPC) and Organized Delivery Systems (ODS) in place
- Small group and individual market reform begun
- Initiated simplification of health care regulations
- Provided tax deductibility on 1996 income tax forms for individuals out of pocket premiums.
- Recommended a 1) State Health Expenditure Accounting System, 2) research on status of the uninsured, and 3) voluntary implementation of CHIMIS

In the Last Ten Years Iowa Moved on Health Reform

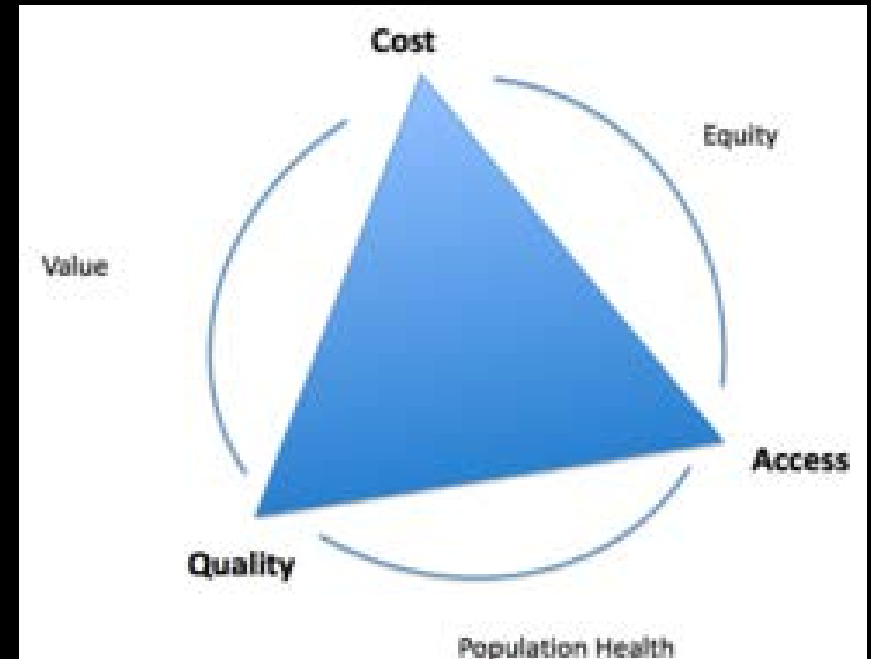
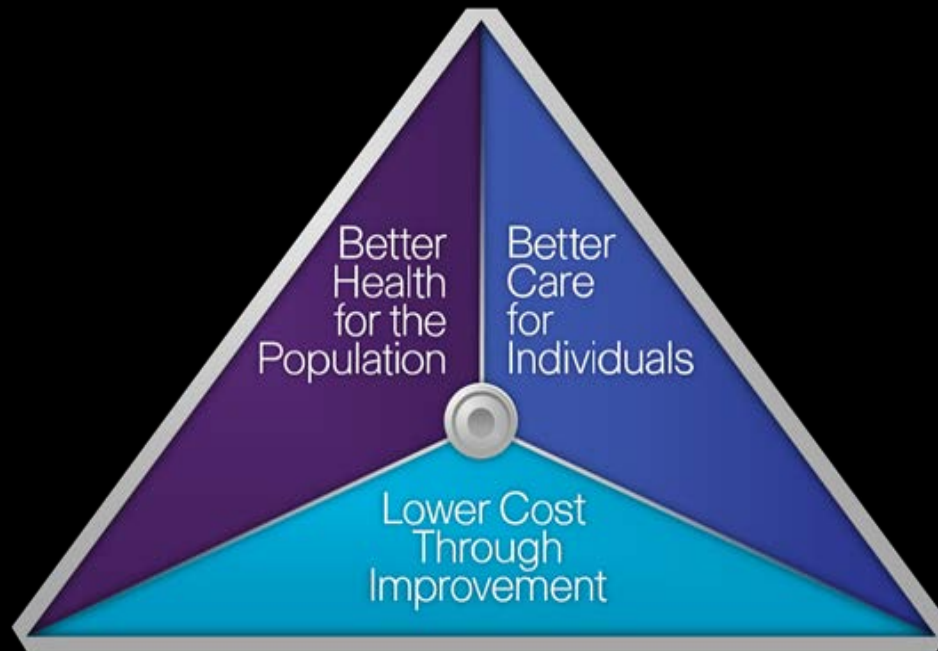
- 2005 – House File 825 - Safety Net Collaborative
- 2007 – House File 841 – The Commission on Health Care Coverage for Families and Workplaces
- 2008 – House File 2539 – Health Care Reform Act
- 2009 – Legislative Health Care Coverage Commission
- 2010 - Senate File 2356 – Iowa Cares Expansion
- 2012 - Senate file 2315 - MH Redesign
- 2013 – Senate File 446 - Health and Wellness Plan

You've got to be very
careful if you don't
know where you're
going, because you
might not get there.

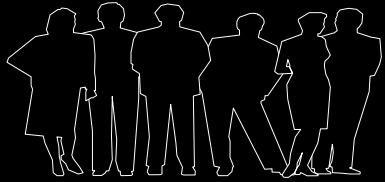


Yogi Berra
Baseball Manager
(Born 1925)

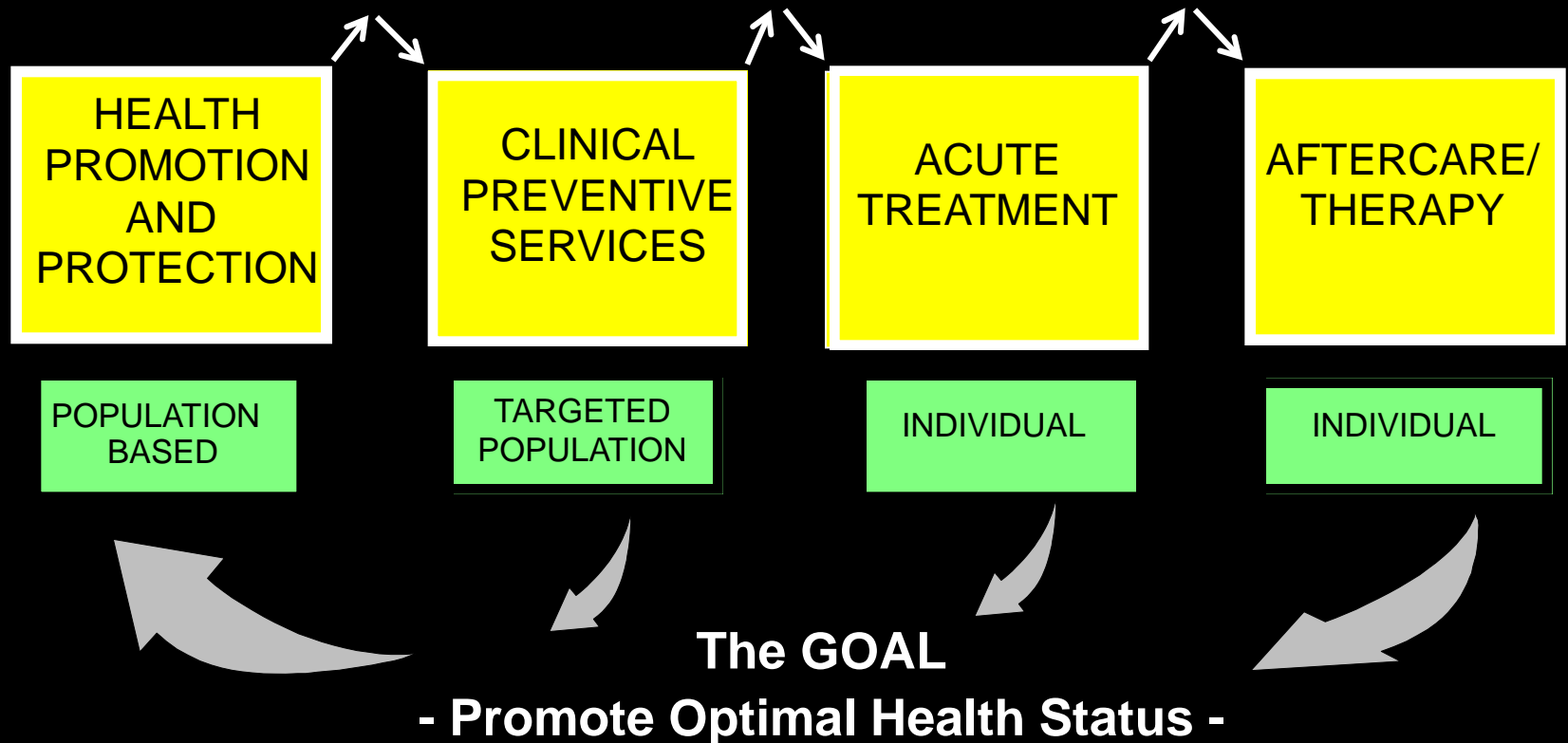
Contemporary Vision: The Triple Solution



SCOPE - THE HEALTH SYSTEM

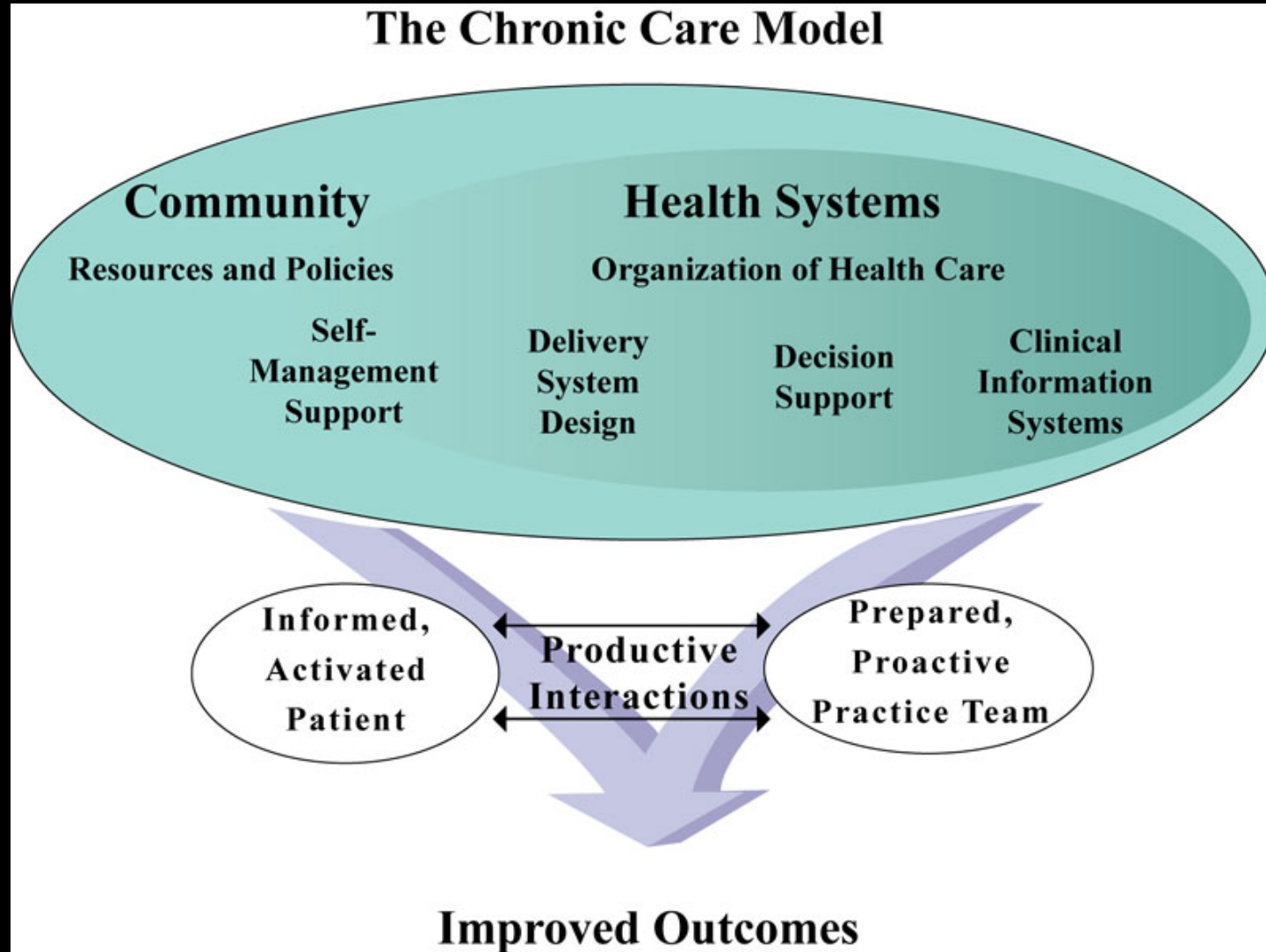


SURVEILLANCE EPIDEMIOLOGY PRIMARY CARE DISCHARGE PLANNING



SCOPE - “Every chronically ill person has a primary care team that organizes and coordinates their care.”

Center for Studying Health System Change 2008



MEANS - Patient Centered Primary Care AKA – A Medical Home

“Medical home” means a team approach to providing health care that **originates**:

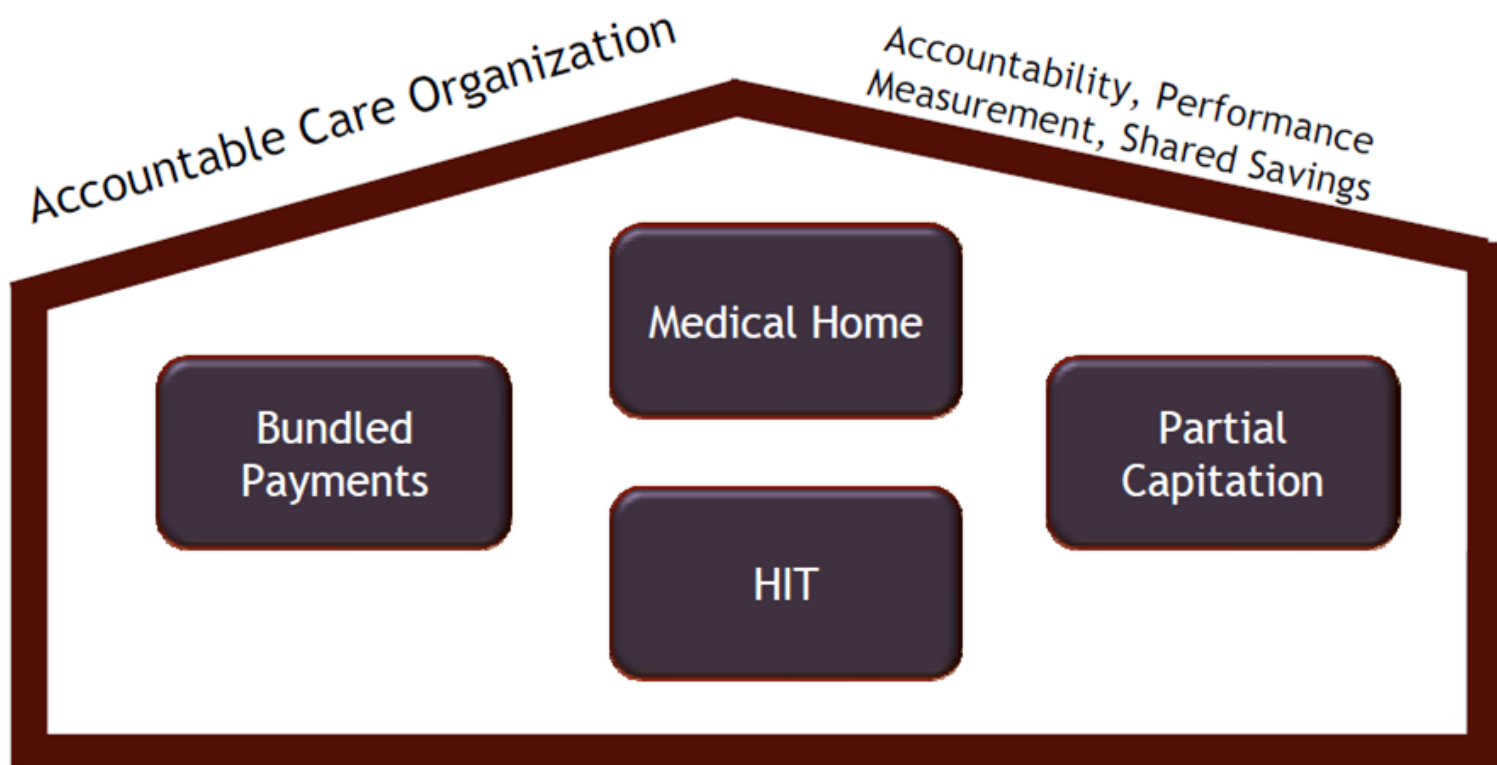
- in a primary care setting;
- fosters a **partnership** among the patient, the personal provider and other health care professionals, and where appropriate, the patient’s family,
- utilizes the partnership to access all medical and nonmedical health related services needed by the patient and the patient’s family to achieve **maximum health potential**;
- maintains a **centralized, comprehensive record** of all health related services to promote **continuity of care**.

MEANS:

The ACO is the overarching structure within which other reforms can thrive

THE DARTMOUTH INSTITUTE
FOR HEALTH POLICY & CLINICAL PRACTICE

Where Knowledge Informs Change

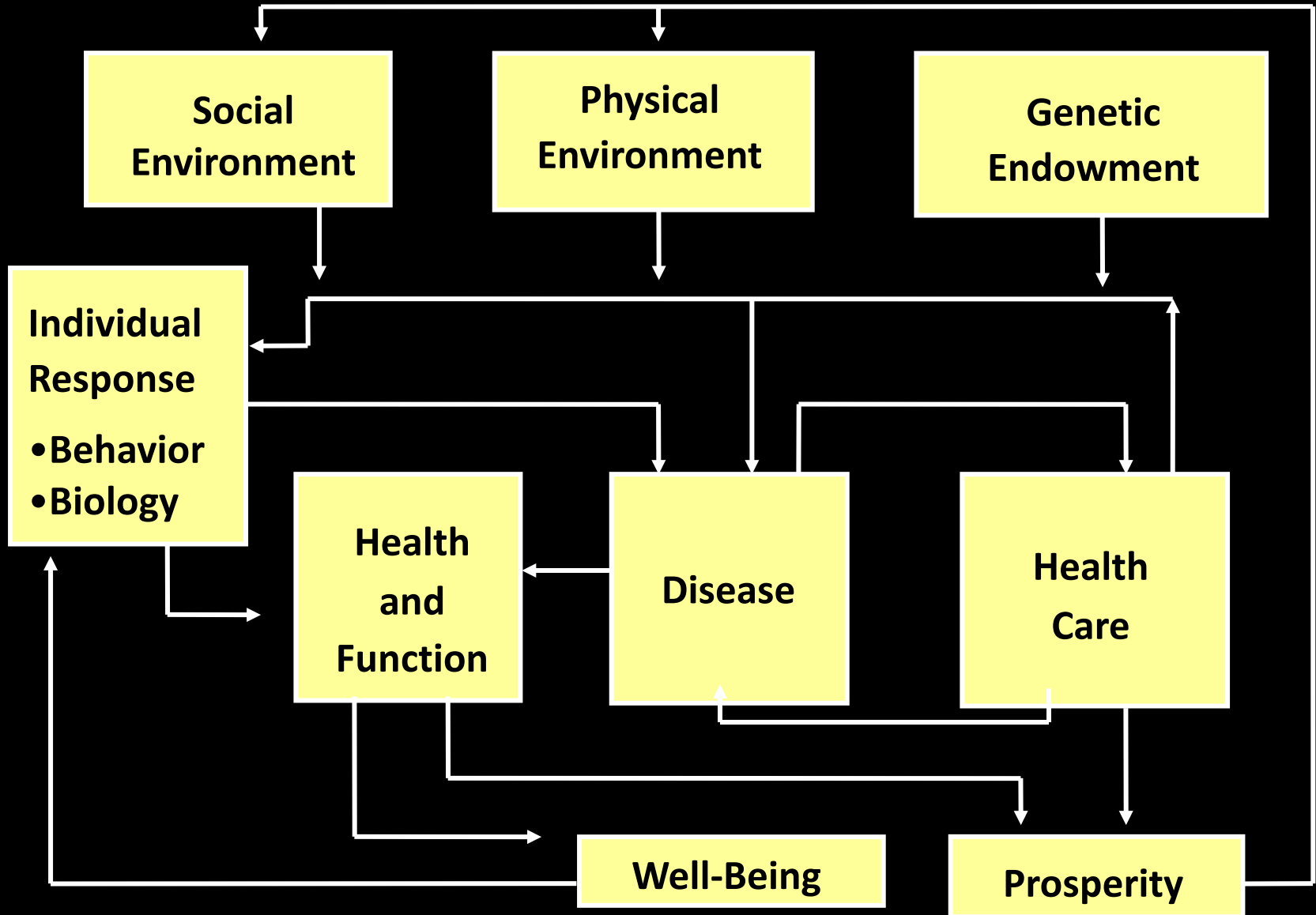


ENGELBERG CENTER for
Health Care Reform
at BROOKINGS

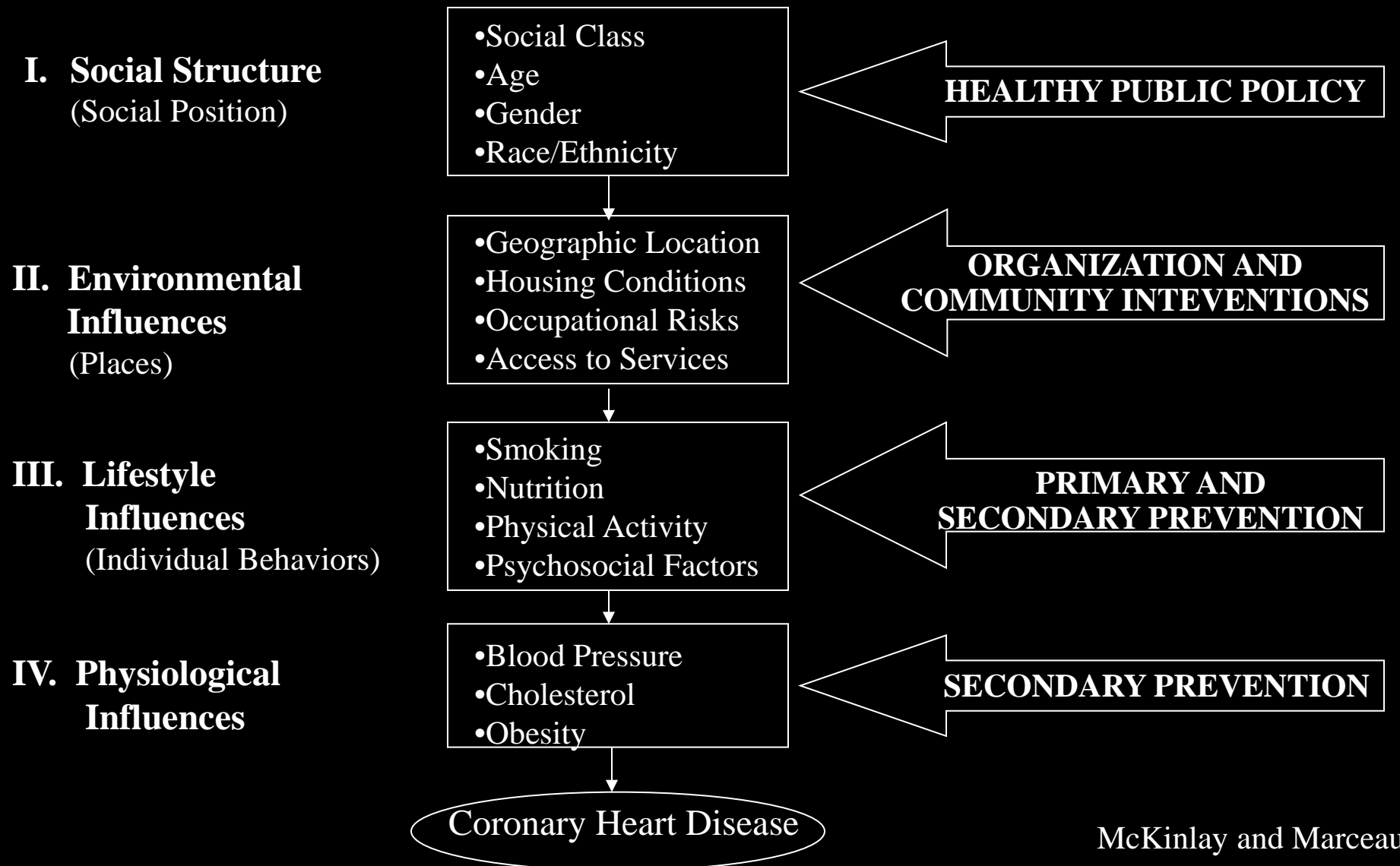
The Dynamic Nature of Public Health

“The fact that health problems emerge mainly in response to conditions of life requires that public health remain highly adaptive, especially when living conditions are changing rapidly.”

The Determinants of Health



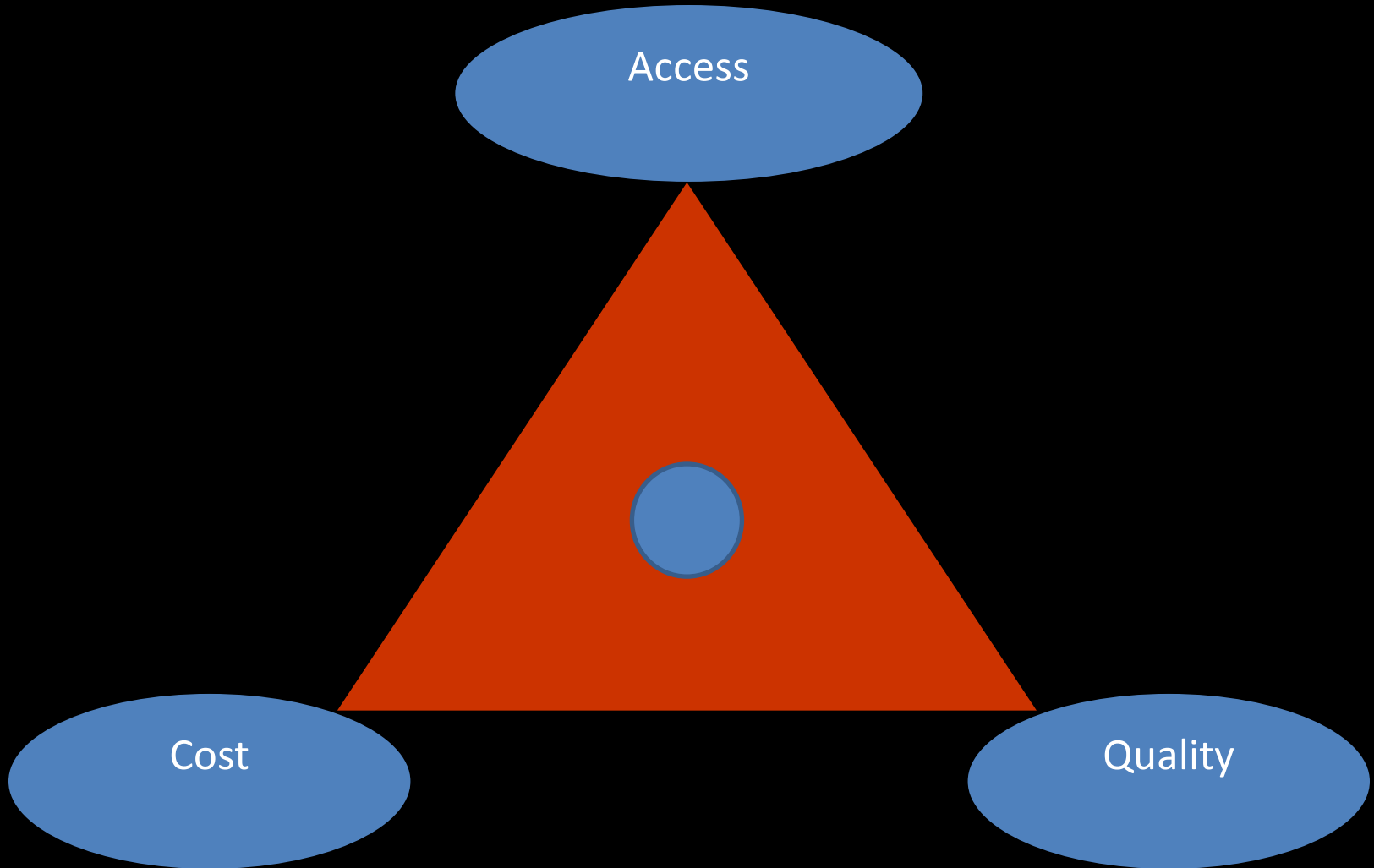
Levels of causation of coronary heart disease and corresponding types of health intervention, i.e. **Determinants of Health**



Keep our eye on the Goal



But the Challenge Remains How Do We Find the Sweet Spot ?



NASHP Agenda and Items to be Discussed

- COVERAGE & ACCESS – Health and Wellness Plan, the Safety Net
- DELIVERY SYSTEMS -Medical Homes and ACOs
- CHILDREN’S HEALTH e.g. CHSC
- COST– Payment Reform and Exchanges
- HEALTH INFORMATION TECHNOLOGY – EMR and Registries
- HEALTH SYSTEM IMPROVEMENT & QUALITY – Outcomes
- LONG TERM & CHRONIC CARE – Ancillary services
- REFORM IMPLEMENTATION- Alignment
- WORKFORCE - Capacity and Capability



Goals and Objectives

